PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT – CHILD CARE PROGRAM
PLAINVIEW, NY 11803

AUTHORIZATION FOR EMERGENCY MEDICAL-SURGICAL TREATMENT

NOTE: It is the firm hope that the authorization granted on this form would never have to be used. However, for the safety of your child, sound medical practice calls for such authorization. In emergency situations wherein, for some reason the parent cannot be contacted immediately, this form may be extremely important. Doctors and hospitals refuse to give any treatment, regardless of how minor, unless they have a notarized authorization from a parent.

THE AUTHORIZATION GRANTED BY THIS FORM WILL BE USED ONLY WHEN NECESSARY AND ONLY AFTER EVERY REASONABLE ATTEMPT HAS BEEN MADE TO CONTACT PARENT OR GUARDIAN.

I understand that in the event I cannot be reached, I hereby consent to and authorize the physician or hospital selected by the Child Care Program or Plainview-Old Bethpage Central School District to hospitalize, secure proper treatment for, to order injections, anesthesia, surgery and any preliminary, further or additional treatments, procedures, tests, etc. necessary at the time, for my child, as named below.

Emergency contact number(s) during Child Care hours: _____

Plainview, New York
Dated:

_____, 20____ **_____** **_____**
Child's Name **Child's School**

I consent to the above: _____
Signature of Parent or Guardian Relationship

_____
Print Name of Signature Above